CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PARTICIPATING PROVIDER

A participating provider is a person who has a current, signed participation agreement with the Department of Medical Assistance Services.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. A copy of the provider agreement can be found within this chapter. All providers must sign the appropriate Participation Agreement and return it to the Provider Enrollment/Certification Unit; an original signature of the individual provider is required. The agreement is time-limited and applies to a specific time period. All participants are required to complete new agreement forms when a name change or change of ownership occurs.

Upon receipt of the above information, a seven-digit Medicaid identification number is assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUESTS FOR PARTICIPATION

In order to become a Medicaid provider of services, the practitioner must request a participation agreement by writing:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

PARTICIPATION REQUIREMENTS

All providers enrolled in the Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreement. Providers approved for participation in the Medical Assistance Program must perform the following activities as well as any other specified by DMAS:

- Immediately notify the Provider Enrollment/Certification Unit at FIRST HEALTH, in writing, of any change in the information, which the provider previously submitted, to the Department;

- Ensure freedom of choice to recipients in seeking medical care from any

institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed;

- Ensure the recipient's freedom to reject medical care and treatment;
- Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, religion, or national origin;
- Provide services and supplies to recipients in full compliance with the requirements of Section 504 of the Rehabilitation Act of 1973 requiring that all necessary accommodations be made to meet the needs of persons with semi-ambulatory disabilities, sight and hearing disabilities, and disabilities of coordination (refer to the section in this chapter regarding Section 504 of the Rehabilitation Act);
- Not require, as a precondition for admission or continued stay, any period of private pay or a deposit from the resident or any other party;
- Not bill the recipient for missed or broken appointments.
- Accept Medicaid payment from the first day of eligibility, if Medicaid eligibility was pending at the time of admission. The nursing facility must accept payment back to the date of eligibility, if the resident was in a certified bed, whether or not the facility knew that Medicaid application had been made;
- Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public;
- Charge the Department of Medical Assistance Services for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public;
- Accept as payment in full the amount reimbursed by the Department of Medical Assistance Services. 42 CFR, Section 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amount paid by the agency;"
- A provider may not seek to collect from a Medicaid recipient, or any financially-responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered. If a third party payer reimburses $5.00 of an $8.00 charge, and Medicaid's allowance is $5.00, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative;

- Accept assignment of Medicare benefits for eligible Medicaid recipients;

- Use Program-designated claim forms and billing invoices for the submission of charges;

- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. (Refer to the section in this chapter regarding documentation.);

  Such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to the section in this chapter regarding documentation.);

- Furnish to authorized State and federal personnel, in the form and manner requested, access to records and facilities;

- Disclose, as requested by the Department of Medical Assistance Services, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance; and

- Hold information regarding recipients confidential. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data are necessary for the functioning of the state agency. The State Agency shall not disclose individual recipient medical information to the public.

Licensed Physicians

Only physicians currently licensed in the Commonwealth of Virginia (or in the state in which he or she practices) to practice as doctors of medicine (M.D.) or doctors of osteopathy (D.O.) may apply for participation in the Virginia Medicaid Program by signing the authorized Participation Agreement, DMAS-101 (see "Exhibits" at the end of the chapter for a sample of the form). Acceptance for participation is based upon the needs of the Program, pursuant to Section 32.1-325 of the *Code of Virginia*. Physicians who, in any of the 50 states, have relinquished or have had revoked their license to practice medicine will have their applications considered on a case-by-case basis, taking into consideration the needs of the Program and its responsibilities to recipients. The agreement(s) must be in effect at the time services are rendered in order for claims to be considered for payment. Each physician will be assigned a Virginia Medicaid provider identification number. Medicaid can pay only for services performed by the participating treating physician or under his or her direct, personal supervision. Records must fully disclose a sufficient amount of information to indicate the extent and nature of the physician's overall supervision and participation in the care and treatment of the patient.

In a teaching setting, the Virginia Medicaid Program will cover the services of an attending

physician (other than an intern or resident) to an individual patient, when the attending physician provides personal and identifiable direction to interns or residents who are participating in the care of his or her patient. In the case of major surgical procedures or other complex or dangerous procedures or situations, such personal direction must include supervision in person by the attending physician. Payment will be made for the services of an attending physician who involves interns and residents in the care of his or her patient only if his or her services to the patient are of the same nature, in terms of responsibilities to the patient that are assumed and fulfilled, as the service he or she renders to his or her other paying patients.

In both the teaching and the non-teaching setting, as evidence that a covered service was rendered under the attending physician's supervision, the medical record must contain his or her signed or countersigned notes which show that he or she personally reviewed the patient's medical history, gave a physical examination, confirmed or revised the diagnosis, and visited the patient.

CERTIFICATION AND RECERTIFICATION

The Virginia Medicaid Program is dependent upon the participation and cooperation of physicians who provide or order health care services. The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with community standards of medical practice.

Physicians, General

Medicaid recognizes the physician as the key figure in determining utilization of health services. The physician decides upon admission to a hospital; orders tests, drugs, and treatments; and determines the length of stay. The Program calls for substantiation of certain physician decisions as an element of proper administration and fiscal control. Payment for certain covered services may be made to a provider of services only if there is a physician's certification concerning the necessity of the services furnished, and, in certain instances, only if there is a physician's recertification to the continued need for the covered services.

- The institutional provider of services is responsible for obtaining the required physician certification and recertification statements and for retaining them on file for verification, when needed, by the intermediary or by the State Agency.

- Each provider of services determines the method by which the required physician certification and recertification statements are obtained. Use of specific procedures or specific forms is not required, so long as the approach adopted by the provider permits verification that required physician certification and recertification statements are entered on or included in forms, notes, or other records a physician normally signs in caring for a patient; a separate form may be used for this purpose. Each certification and recertification statement must be separately signed by a physician, except as otherwise specified in this section.

- The requirements for recertification (and for certification for inpatient hospital

services furnished) set forth in this section specify certain information that must be included in the physician's statement. This required information need not be repeated in a separate statement if, for example, it is contained in the physician's progress notes. The physician's statement may merely indicate that the required information is contained in the patient's medical record, if this is so.

- Providers of services are expected to obtain timely certifications and recertifications. However, delayed certifications and recertifications can be honored when, for example, the patient was unaware of his or her eligibility for the benefits when he or she was treated. Delayed certifications and recertifications must include or be accompanied by an explanation for the delay, including any medical or other evidence the physician or provider considers relevant for explaining the delay. A delayed certification and one or more delayed recertifications may appear in one signed statement.

Inpatient Hospital Services

Certification

Federal regulation 42 CFR 456.60 requires a physician certification that inpatient hospital services are necessary for each hospitalized recipient. A physician must certify the need for inpatient care at the time of admission. The certification must be in writing and signed or initialed by an individual clearly identified as a doctor of medicine (M.D.) or doctor of osteopathy (D.O.). The certification must be dated at the time it is signed.

The certification may be either a separate form to be included with the patient's records or a stamp stating "Certified for Necessary Hospital Admission" which is to be made an **identifiable** part of the physician orders, history and physical, or other patient records. This certification must be signed and dated by the physician at the time of admission or, if an individual applies for assistance while in the hospital, before payment is to be made by the State Agency.

Federal regulation 42 CFR 456.80 requires that a written plan of care be established at the time of admission or before payment for care can be authorized for each recipient. The plan must be an identifiable part of patient records and must include:

- Diagnosis, symptoms, complaints, and complications indicating the need for admission;
- A description of the functional level of the individual;
- Any orders for medication, treatment, restorative or rehabilitative services, activities, social services, and diet;
- Plans to continue care as appropriate; and
- Plans for discharge.

Recertification

A physician, physician assistant, or nurse practitioner, acting within the scope of practice as defined by State law and under the supervision of a physician, must recertify at least 60 days after certification for each recipient that inpatient hospital services are needed.

This required information need not be repeated in a separate statement if, for example, it is contained in the physician's progress notes. The physician's statement may merely indicate that the required information is contained in the patient medical record, if this is so.

Long-Term Care Facilities
(Effective Date: Revised October 1, 1990)

Physician Certification and Recertification

In each case for which payment for inpatient nursing facility services or inpatient mental hospital services is made under the State Plan:

- In a nursing facility, a physician must approve a recommendation that an individual be admitted. The nursing home preadmission screening shall serve as the physician's admission or initial recommendation if the date of the screening occurred within 30 days of the date of the admission to a nursing facility. Recertification is not required for nursing facility residents.

- In a facility for the mentally retarded, the physician or nurse practitioner or clinical nurse specialist who is not employed by the facility and who is working in collaboration with a physician must recertify that patients continue to require the specific level of care at least once every 365 days.

- In mental hospitals, recertifications are required in intensive psychiatric units and in hospital areas (medical-surgical units) at least every 60 days. In nursing facility areas, units, or buildings on the grounds of State mental hospitals, the certification requirements are the same as for nursing facilities, based on the certification of the unit.

  Note: The initial certification for either level of care must be dated and signed within 30 days prior to or at the time of admission. The date of the next recertification is computed from the date the initial certification was actually signed.

- Certification is not considered a pro forma act but rather a medical decision based on the professional evaluation of the patient's needs. The certification must justify the reasons for nursing facility placement and be signed (name and title) and dated (month, day, and year) by the attending physician or nurse practitioner or clinical nurse specialist as qualified on the preceding page. (Rarely would a diagnosis alone be acceptable as justification for nursing facility care.)

- For purposes of determining compliance, a recertification shall be considered to

have been completed on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required if the physician or other person making the certification provides a written statement showing good cause why the recertification did not meet the schedule. The statement of good cause must be filed in the patient's record and be made available to the Department of Medical Assistance Services staff when audits for compliance are made. In the absence of clarifying regulations, the agency has not defined "good cause." Therefore, any statement made by the physician purporting to show good cause will be accepted if made in writing by the physician, nurse practitioner, or clinical nurse specialist responsible for making such recertification and filed in the patient's record.

- The Department of Medical Assistance Services accepts recertifications written and signed by nurse practitioners or clinical nurse specialists. Private-pay patients who apply for Medical Assistance must have their certification signed by the physician or other qualified health professional at the time an application is made for Medicaid eligibility determination.

- Certification reflecting the need for nursing home placement and the physician's progress note of the observed medical condition may be contained in the same note. However, these are two separate requirements, and one cannot be substituted for the other.

NOTE: All physician or other health care professionals' documentation, including certifications, must be signed with the initials, last name, and title. All documentation must be completely dated with the month, day, and year. Mailing in certifications, orders, or progress notes is prohibited.

Physician's Plan of Care and Orders

A physician must approve a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. All residents must be seen by a physician, and orders must be renewed at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter (effective April 1, 1992). The most current page of the physician's orders must be the first page of the physician's order section in the medical record. "Renew orders" is acceptable if all current orders are on the same page of the physician's order sheet.

The plan of care must include diagnoses, symptoms, complaints, and complications, and any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and plans for discharge. Orders must be specific for individual needs, and all orders must be complete (i.e., the medication orders must include the medication name, dosage, frequency, and route of administration; restraint orders must include the specific times in which the restraint may be applied, the type of restraint to be used, and the periods of time in which restraint will be removed for resident exercise).

A physician visit is considered timely if it occurs no later than 10 days after the date the visit was required. The initial physician visit must be made by the physician personally.

Subsequent required physician visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner under the physician's supervision.

In facilities for the mentally retarded, the physician must also review the use of psychotropic drugs on at least a quarterly basis for adverse side effects and record the review in the medical records of residents receiving a psychotropic drug. If psychotropic drugs are utilized, there must be a behavioral program for that resident.

Progress Notes

It is expected that the physician will visit the resident and write progress notes, which reflect the observed medical condition of the resident. Physician progress notes should record any significant change between visits or record or elaborate when the resident's condition is unchanged. The record must indicate the progress at each visit, any change in the diagnosis or treatment, and the resident's response to treatment.

Progress notes must be written for every nursing facility visit to a recipient and at least every 90 days. If a physician chooses to delegate the alternate patient visits (as described above), the physician assistant or nurse practitioner must write the progress notes for visits in which he or she was involved. Significant changes or problems in the patient's condition must be immediately reported to the physician.

DMAS will accept documentation written by an alternate physician, such as the Medical Director.

Home Health Services

Home health services include periodic nursing care under the direction of a physician. Such services are provided by participating home health agencies and can be used effectively by the physician for post-hospital care and periodic nursing care.

To be eligible for home health services, the patient must be essentially homebound. While this does not mean bedridden, the patient must meet at least one of the following conditions to be considered homebound:

- The patient's physical condition is such that there exists a normal inability to leave home without the assistance of others or the use of special equipment;
- The patient has a mental or emotional problem which is manifested in part by refusal to leave his or her home environment or is of such a nature that it would not be considered safe for him or her to leave home unattended;
- The patient is ordered to restrict his or her activity by the physician due to a weakened condition following surgery or heart disease of such severity that stress and physical activity must be avoided; or
- The patient has an active communicable disease, and the physician restricts the patient to prevent exposing others to the disease.

In addition, under the following conditions, Medicaid will reimburse for home health services when a patient is not essentially homebound when:

- The combined cost of transportation and medical treatment exceeds the cost of a home health services visit;
- The patient cannot be depended upon to go to a physician or clinic for the required treatment; as a result, he or she would, in all probability, have to be admitted to a hospital or nursing facility because of complications arising from the lack of treatment;
- The visits are for a type of instruction to the patient which can better be accomplished in the home setting; or
- The duration of the treatment is such that rendering it outside of the home is not practical.

When home health services are provided because of one of the above reasons, an explanation must be included on the Home Health Certification and Plan of Treatment (HCFA 485, 486, and 487 forms.

Certification
The required physician's statement should certify that:

- The home health services were required because the individual was confined to his or her home (as described above).
- The individual needed skilled nursing care or home health aide services on an intermittent basis, or he or she needed physical or occupational therapy or speech-language pathology services.
- A plan for furnishing such services to the individual has been established and is periodically reviewed by a physician.
- These services were furnished while the individual was under the care of a physician. The physician may be the patient's private physician or a physician on the staff of the home health agency or a physician working on an arrangement with the institution which is the patient's residence or, if the agency is hospital-based, a physician on the hospital or agency staff.

Recertification
A recertification is required at intervals of at least once every two months, should be signed by the physician who reviews the plan of treatment, and should preferably be obtained at a time when the plan of treatment is reviewed. The recertification statement should indicate the continuing need for services and should estimate how long home health services will be needed.

Certification and Recertification for Recipient Who Receives Services Prior to Entitlement

If any individual receives services before his or her entitlement to Medicaid benefits, the timing of certification and recertification will be determined as if the date of entitlement was the date of admission. For example, if any individual is admitted to a hospital before entitlement, the date of entitlement will determine the timing of certification and recertification, not the date of admission.

Use of Rubber Stamps for Physician Documentation
[Effective Date: 1-23-92]

All physician or other health care professionals' documentation, including certifications, must be signed with the initials, last name, and title. DMAS will allow the use of rubber stamps for physician signatures when the use is consistent with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation requirements and physician documentation. When a rubber stamp is used, the individual whose signature the stamp represents must provide DMAS with a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. All rubber-stamped signatures are also required to be accompanied by the initials of the physician.

The signature waiver form must be received 30 days prior to the date of the anticipated use of the rubber stamp. (See “Exhibits” at the end of this chapter for a sample of this form.) All documentation must be completely dated with the month, day, and year. Mailing in certifications, orders, or progress notes is prohibited.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT OF 1973

Section 504 of the Rehabilitation Act of 1973 provides that no handicapped individual shall, solely by reason of the handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for making provision for handicapped individuals in his or her program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. By signing the check, the provider indicates compliance with Section 504 of the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

REQUIREMENTS OF THE CIVIL RIGHTS ACT OF 1964

All providers of care and suppliers of services under the contract with DMAS must comply with the requirements of Title VI of the Civil Rights Act of 1964 which requires that services be provided to Medicaid recipients without regard to race, color, or national origin.

UTILIZATION OF INSURANCE BENEFITS

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under Medical Assistance shall be reduced to the extent that they are available through other federal, State, or local programs; coverage provided under federal or State law; other insurance; or third-party liability.

Health, hospital, workers' compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare)** - Virginia Medicaid will pay the amount of any deductible or coinsurance up to the Medicaid limit for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.

- **Workers' Compensation** - No Medicaid Program payments shall be made for a patient covered by Workers' Compensation.

- **Other Health Insurance** - When a recipient has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

- **Liability Insurance for Accidental Injuries** - The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and the Virginia Medical Assistance Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in the Virginia Code Section 8.01-66.9. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

  In the case of an accident in which there is a possibility of third-party liability or if the recipient reports a third-party responsibility (other than those cited on his Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the physician is requested to forward the DMAS-1000 to the attention of the Third-Party Liability Casualty Unit, Virginia Medical Assistance Program, 600 East Broad Street, Richmond, Virginia 23219. (See “Exhibits” at the end of the chapter for a sample of the form.)

DOCUMENTATION

The provider agreement requires that the medical records fully disclose the extent of services provided to Medicaid recipients. Medical records must clearly document the medical necessity for covered services. This documentation must be written at the time the

service is rendered and must be legible and clear in the description of the services rendered.

The provider is to select from the *Physicians' Current Procedural Terminology, Fourth Edition* (CPT) the procedure code which most appropriately describes the service rendered and documented. Please pay particular attention to the definitions and descriptions regarding classifications of the evaluation and management (E/M) services for new and established patients as contained in the introduction to the CPT. These same definitions and descriptions will be used to evaluate the documentation during Program audits of medical records.

A pre-existing written protocol, defined as a narrative explanation of an office or examination procedure, with contemporaneous medical record documentation may be considered in addition to the medical record to satisfy the documentation requirements. The protocol is not acceptable as a replacement for appropriate medical record documentation.

Specific points to be recorded in the medical records to meet the documentation requirements should include the following as appropriate:

- The present complaint;
- A history of the present complaint, the past medical history applicable to the complaint, and the family history when applicable to the complaint;
- The positive and negative physical examination findings pertinent to the present complaint;
- The diagnostic tests ordered, if any, and the positive and negative results;
- The diagnosis(es);
- The treatment, if any, including referrals. Any drugs prescribed as part of the treatment must have quantities and the dosage entered in the medical record;
- The observed medical condition of the patient, the progress at each visit, any change in the diagnosis or treatment, and the response to the treatment. Progress notes must be written for every office, clinic, nursing facility, hospital, or psychotherapy visit billed to Medicaid;
- The length of time and type of therapy (i.e., individual or group) for psychotherapy.
- The provider in solo practice must have a method of identifying the recipient and the treating physician for each service. However, entries from covering physicians must be signed by the covering physicians.
- In group practices, providers must have a verifiable method of identifying the recipient and the treating physician for each service.

- The documentation for care rendered by personnel under the direct, personal supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.

Examples of Medical Record Documentation

Office Visit With Follow-Up Visit

John Doe

Jan. 20, 1989 BP 120/70 T 98.6
C/O itching over back and legs x 2 wks.
Macular excoriated eruptions over back and lower legs. None on chest or abdomen.
HEENT WNL. Chest clear, heart regular.
Dermatitis, non-specific
Zone A Forte BID & HS
Prednisone 5 mg. TID #12
Chlorofed q12h
rtn 2 wks
Bob Roe, M.D.

Feb. 3, 1989 BP 110/70 T 98.6
Itch has resolved. C/O headache
HEENT WNL, chest clear, heart regular, abd soft ext WNL.
Headache
Esgic tab #60 1-2 tab q4h prn
Bob Roe, M.D.

Pediatric Office Visit With Follow-Up Visit

Jimmy Doe

Jan. 20 1989
CC: coughing, worse at night. Pulling at ears T 99
TMs injected with fluid. Tonsils injected and red. Coarse rhonchi with squeaks.
HCT 27.4 Strep screen- pos.
Plt 381,000
WBC 6.6
Grans 30-46%
Lymphs 36-54%
Acute tonsillitis
BOM
Anemia
Slophyllin 80 1 tsp QID
Amoxicillin susp. 250 mg. TID
Return 10 days
Jane Roe, M.D.

Jan. 31, 1989 T 98.8
Still coughing. Not pulling at ears.
Tonsils less injected. TMs less injected. Coarse rhonchi.
Resolving tonsillitis
Resolving BOM
URI
Rondec syrup 1 tsp q 4h prn
Jane Roe, M.D.

Psychotherapy Visit

John Smith

10/2/89
Individual therapy one hour. Therapy focused on the anxiety Mr. Smith experiences when in public places such as a grocery store or shopping mall. Mr. Smith reported following through with recommendations made during last session in regards to increasing the amount of time spent in a store while practicing relaxation exercises. Plan is to continue relaxation training in office coupled with systematic desensitization along with increased exposure to feared situations outside the office.
Jack Brown, M.D.

Jane Jones

10/2/89
Individual therapy one hour. Ms. Jones continues to report depressed feelings surrounding the break up of her marriage. Therapy focused on identification of origins of these feelings in relation to other losses in her life. Encouraging alternative coping style and plan to use a more cognitively based approach to deal with negative thought patterns.
Jack Brown, M.D.

- All laboratory tests billed to the Program must have documented results. Those laboratory tests listed as quantitative tests by the CPT must be documented by a numerical result. Qualitative tests are to be documented by positive or negative. Those laboratory services requiring descriptive results are to be fully-documented. Documentation examples are listed below:

  Quantitative tests:
  WBC - 7,000/mm^3
  Glucose - 85 mg/dl

  Qualitative tests:
  Monoscreen - positive
  Pregnancy test - negative

  Descriptive tests:
  Urine microscopy - clear, yellow-brown, few wbc, rare renal epithelial cell
  Urine culture - greater than 10^5/ml E. coli

PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives Program information. Since DMAS does not always know which provider groups have multiple offices or which groups use one central office, providers may receive multiple copies of manuals, updates, and other publications sent to the same location. Individual providers may request that publications not be mailed to them by completing a Mailing Suspension Request form and returning it to the First Health - Provider Enrollment Unit at the address given on the form. The Mailing Suspension Request form must be completed and signed by each provider within the group who is requesting that Program information not be sent. The address is:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

(See the "Exhibits" section at the end of the chapter for a sample of the form.)

TERMINATION OF PROVIDER PARTICIPATION

The participation agreement will be time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to its expiration.

A participating provider may terminate his or her participation in Medicaid at any time. Thirty (30) days' written notification of voluntary termination should be made to the

Director, Department of Medical Assistance Services.

DMAS may terminate a provider from participation upon thirty (30) days' written notification. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice.

The *Code of Virginia*, Chapter 10, Department of Medical Assistance Services, Section 32.1-325(c), mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

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A provider convicted of a felony in Virginia or in any other of the 50 states must, within thirty (30) days, notify the Program of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of State law.

RECONSIDERATION OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action. Adverse action for purposes of this section includes termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review decisions.

The reconsideration process will consist of three phases: a written response and reconsideration to the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have 15 days' notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (Section 9-6.14:1 et seq.) and the State Plan for Medical Assistance provided for in Section 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

Any legal representative of a provider must be duly licensed to practice in the Commonwealth of Virginia.

Repayment of Identified Overpayments

Pursuant to Section 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, Section 32.1-313.1. Interest will not apply pending appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

EXHIBITS

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Commonwealth Of Virginia
Department of Medical Assistance Services
Medical Assistance Program
Participation Agreement

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

☐ If you wish to be a MEDALLION PCP, check this box. The MEDALLION provider enrollment form must be attached.
☐ If you are already a MEDALLION provider, check this box.

This is to certify:

	PAYMENT/CORRESPONDENCE ADDRESS	**PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)**
INDIVIDUAL NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider is authorized to practice under the laws of the state in which he is licensed and practicing and is not as a matter of state or federal law disqualified from participating in the Program.**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of l973 29 USC.794) VMAP.**
3. **The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.**
6. **The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.**
7. **Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.**
9. **This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the Program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **If qualified to be a Primary Care Provider, the applicant agrees to comply with all applicable MEDALLION state and federal laws, administrative policies and procedures of DMAS, and the requirements identified in Appendix A as from time to time amended.**
12. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For Provider of Services:

For First Health's use *only*

Director, Division of Program Operations Date

Original Signature of Provider **Date**

Provider Specialty

_____**City OR** _____**County of** _____

Board License Number **(Area Code) Telephone Number**

IRS Identification Name (Required)

mail or fax **one** completed **original** agreement to:

First Health - VMAP-Provider Enrollment Unit
PO Box 26803
Richmond, VA 23261-6803
1-804-270-7027

IRS Identification Number (Required) **UPIN**

Medicare Carrier and Vendor Number

APPENDIX A
MEDALLION PROVIDER REQUIREMENTS

Medicaid enrolled physicians with a specialty of obstetrics/gynecology, general/family practice, pediatrics, internal medicine, or other specialties approved by the Department of Medical Assistance Services. Qualified Health Department Clinics, Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) may be MEDALLION primary care providers (PCP). The MEDALLION PCP agrees to the following:

1. Function in the role of PCP for MEDALLION. In this role, the Provider will carry out all routine preventative and treatment services to MEDALLION patients assigned to the PCP's practice. This will include Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and maintenance of a comprehensive medical record for each patient assigned to the PCP's MEDALLION panel. In particular, the PCP will provide and/or coordinate patient management for all preventive, primary and specialty health care services. The PCP must have admitting privileges at a local accredited hospital or must make arrangements for admissions with a physician who does have admitting privileges.

2. Make available 24-hour, 7 days per week access by telephone to a live voice (an employee of the PCP or an answering service) or an answering machine which will immediately page an on-call medical professional so that referrals can be made for non-emergency services or so information can be given about accessing services or how to handle medical problems during non-office hours. Maintain reasonable and adequate office hours for assigned patients, and not discriminate against those patients in regards to office hours available.

3. Coordinate all other Medicaid authorized care for each patient enrolled in his or her MEDALLION caseload including referral to specialty providers for medically necessary services. In referring for specialized evaluation and/or treatment, the PCP will provide the specialist with authorization to cover appropriate testing and treatment. This authorization may be verbal or written for a period appropriate to the illness. The PCP will document all referrals in the patient's medical record.

4. The PCP will not restrict patient access to services exempt from MEDALLION referral requirements as specified by DMAS as exempted services which includes family planning, emergency services, obstetrical, and gynecological services.

5. Complete a BabyCare risk screen on every MEDALLION patient assigned to the PCP's panel who is eligible to receive a risk screen. If the patient is determined to be at risk and eligible to receive BabyCare services, the PCP must either provide BabyCare services (if the PCP is an enrolled BabyCare Provider) or refer the eligible patient to a Medicaid enrolled BabyCare Provider.

6. Enroll and participate in the Commonwealth of Virginia's Vaccines for Children (VFC) Program.

7. Provide case management, primary care and health education to enrollees that fosters continuity of care and improved provider/patient relationships.

8. Not refuse an assignment or disenroll a patient or otherwise discriminate against a patient solely on the basis of age, sex, race, physical or mental handicap, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider.

9. The PCP may request reassignment of a MEDALLION patient to another PCP, if the patient/PCP relationship is not mutually acceptable, patient's condition or illness would be better treated by another PCP or other reasons approved by DMAS. The PCP must notify the patient in a direct and timely manner of the PCP's desire to remove the patient from their caseload and keep the patient in the PCP's panel until another PCP is assigned or until the patient has been disenrolled from MEDALLION.

10. Providers will receive the usual Medicaid fees for services rendered (physician will also receive a monthly case management fee for each client assigned). See the MEDALLION supplement of the Medicaid Physician manual for specific billing instructions.

11. The PCP's Medicaid Provider Number will be used as the MEDALLION identification number.

12. In the event, the PCP fails to comply with these provisions, appropriate sanctions, up to and including termination from participation as a MEDALLION PCP, will be applied by DMAS. See paragraph (10) of the Medicaid Participation Agreement with respect to appeals, and the MEDALLION supplement to the Physician's Provider Manual with respect to sanctions.

13. The requirements outlined in this appendix will expire concurrent with any termination or expiration of the Provider Participation Agreement. However, these requirements may be terminated for any reason on thirty (30) days notice by either party without mandatory termination of the Agreement.

PLEASE KEEP FOR YOUR RECORDS!

First Health
Services Corporation

SERVICE CENTER AUTHORIZATION
SIGNATURE WAIVER
PHARMACY POINT-OF-SALE

Please review and check the blocks which pertain to you:

☐ **COMPUTER GENERATED CLAIMS:**
I certify that I have authorized the following service center to submit computer generated invoices (by modem, diskette or tape) to Virginia Medicaid:

_____
(Service Center Preparing Invoices)

Service center code: _____ **Magnetic Tape RA:** YES NO (Circle One)

Prior service center code: _____

☐ **SIGNATURE WAIVER:**
I certify that I have authorized submission of claims to Virginia Medicaid which contain my typed, computer generated, or stamped signature.

☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return completed form to:

First Health
VMAP-PEU
Banks Bros. Building
4461 Cox Road, Suite 102
Glen Allen, VA 23060-3331
1-804-270-5105

VIRGINIA

Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia
23219

THIRD PARTY LIABILITY INFORMATION REPORT

(FOR MEDICAID PROVIDERS' USE)

This form MUST be submitted to the Department of Medical Assistance Services within 30 days after a service is rendered to a Virginia Medicaid recipient for the treatment of accident related injuries. Federal Regulations (42CFR - 433.138) require the Department of Medical Assistance Services to exert positive efforts toward locating liable third parties and to diligently seek refunds of applicable liability payments. Please complete this form to the best of your knowledge to assist us in this effort. Statutory authority is provided for full recovery of funds from liable third parties in Section 8.01-66.9 of the Code of Virginia.

PLEASE TYPE OR PRINT

NAME OF RECIPIENT: _____
(LAST) (FIRST) (MI)

RECIPIENT'S ELIGIBILITY NO. _____ DATE OF INJURY _____

TYPE OF ACCIDENT _____ DATE YOUR SERVICE BEGAN _____
(WORK, AUTO, HOME, GUNSHOT, ETC.)

NAME OF ATTORNEY _____

ADDRESS _____

(IF RECIPIENT HAS AN ATTORNEY, THE FOLLOWING INFORMATION IS NOT NEEDED.)

NAME OF INSURANCE COMPANY _____

ADDRESS _____

NAME OF INSURED PERSON _____

POLICY NO. _____ CLAIM NO. _____

COMMENTS _____

DIAGNOSIS _____ NAME OF PROVIDER _____

IS TREATMENT COMPLETED _____ YES _____ NO

DATE _____ BY _____

Providers will not be involved in litigation or collection attempts by the Department of Medical Assistance Services nor will reimbursement to the provider be withheld as a result of submitting this form.

PLEASE MAIL TO:

THIRD PARTY LIABILITY/CASUALTY
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 E. BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

DMAS - 1000 R9/87

First Health Services Corporation

MAILING SUSPENSION REQUEST
SERVICE CENTER AUTHORIZATION
SIGNATURE WAIVER
PHARMACY POINT-OF-SALE

Please review and check the blocks which pertain to you:

- ❑ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid memos, forms, or manual updates under the Medicaid provider number given below.

- ❑ **COMPUTER GENERATED CLAIMS:**
  I certify that I have authorized the following service center to submit computer-generated invoices (by modem, diskette or tape) to Virginia Medicaid:

  _____
  (Service Center Preparing Invoices)

  Service center code: _____ **Magnetic Tape RA:** YES NO (Circle One)

  Prior service center code: _____

- ❑ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid which contain my typed, computer generated, or stamped signature.

- ❑ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-5105